

# **MORTALITY IN LONG TERM CARE**

**A Report to  
Chair, House Committee on Human Services  
Chair, Senate Committee on Health and Welfare**

**Respectfully submitted,**

**Patrick Flood, Commissioner  
Department of Disabilities, Aging and Independent Living  
Agency of Human Services**

**Paul Jarris, Commissioner  
Department of Health  
Agency of Human Services**

**January 2006**

**This document is available in alternative format upon request.**

## **Report on Mortality in Long Term Care**

The 2005 Legislature directed the Department of Disabilities, Aging and Independent Living and the Department of Health to study what it would take to annually review all deaths in Vermont's long term care system. Staff from both departments met three times, including staff of the Medical Examiner's Office. Two of the meetings included representatives of the Long Term Care Ombudsman Program; the Vermont Health Care Association; William Apao, Vermont Department of Health; Dorothy Fisher, MD, Medical Director, Wake Robin; Patrick Flood, Commissioner, Department of Disabilities, Aging and Independent Living; Laine Lucenti, Director, Division of Licensing and Protection; Jackie Majoros, State Ombudsman; Linda Phyphers, Administrator, Wake Robin; Steven Shapiro, M.D., Vermont Department of Health, Medical Examiners Office; and Mary Shriver, Executive Director, Vermont Healthcare Association.

We reviewed current activities for reviewing deaths in long term care and discussed future options.

### **Current Activities**

Currently, at any point in time, there are approximately 1200 individuals in the Home Based Waiver. Turnover is approximately 50%, so in a given year approximately 1800 persons would receive home based services. Although data on deaths is not kept by program, we estimate that approximately 1700 deaths occur each year in this long term care system (approximately 1400 in nursing homes and 300 in the Home Based Waiver). These numbers do not include the thousands of individuals receiving home based services outside of this particular program, including the many who do not participate in any public programs.

Current Vermont Nursing Home regulations and Residential Care Home regulations require that each facility report to the Division of Licensing and Protection (DLP) any untimely death that occurs as a result of an untoward event, such as an accident that results in hospitalization, equipment failure, use of restraint, etc., shall be reported to the licensing agency by the next business day, followed by a written report that details and summarizes the event. In addition, the department is in process of drafting Home Health Agency regulations that will include similar requirements to report untimely or unanticipated deaths.

In state fiscal year 2005, DLP received 16 reports of untimely deaths in nursing homes. All were investigated. In 6 cases, a regulatory deficiency was cited. Of that number, 1 of the nursing facilities was cited for regulatory violations related to the untimely death.

In SFY 2006 to date, DLP has received 11 reports of untimely deaths in nursing homes. All have been investigated. Upon investigation, 1 facility had deficiencies related to the untimely death.

DLP and the Medical Examiner's Office work closely together now in referring cases.

## **Review of Deaths**

All deaths occurring in Vermont – about 5000 each year – are reported to the Department of Health (DOH), Office of Vital Records. Death certificates document the cause and manner of death and other factors that contribute to the death. Most deaths are consistent with a known disease process (e.g., heart disease or cancer). But about 20% of deaths (about 1000 each year) are unnatural, unusual, or occur under suspicious circumstances (18 V.S.A. § 5205). These deaths are referred to the Department of Health, Office of the Chief Medical Examiner (OCME), along with any other deaths that may be brought to the attention of the OCME by a concerned citizen, health care worker, etc. The OCME, in conjunction with law enforcement, reviews each of these deaths, and when deemed necessary by the chief medical examiner or by a state's attorney, the OCME conducts an autopsy. Each year, the OCME performs about 400-500 autopsies.

In addition, the OCME reviews death certificates of all persons cremated in Vermont (18 V.S.A. § 5201). Currently, this is approximately half (48%) of all deaths. Whenever this review raises a question about the death or the death certificate, the OCME contacts the certifying physician and discusses the problem. In some cases (about 100 per year), the OCME examines the body before issuing a cremation permit.

Given that the death certificate is such a vital instrument for monitoring public health and safety, the Department of Health continually measures the quality of death certificates and works to improve death reporting systems. The Office of Vital Records checks death certificates and occasionally follows-back on missing or unusual information on death certificates. Beginning in 2002, the OCME reviewed nearly all death certificates in the state, and found that about a third lacked complete or adequately specific cause of death statements, and about 5% had significant errors. We are currently designing a new web-based electronic death registration system that will improve timeliness, efficiency, and data quality of death certificates.

It is important to note that the death surveillance systems described above, and the improvements planned for those systems, are designed to meet the needs of public health and law enforcement. They are not currently designed to address quality assurance of the long term care system. In order to conduct thorough and intensive investigations of untimely deaths occurring in long term care settings, it would require additional funding and staffing of the OCME.

The Department of Disabilities, Aging and Independent Living (DAIL), the Department of Health, and the Vermont Health Care Association believe that, overall, the current system contains sufficient oversight and review of untimely deaths, although some modest improvements can be made. Abuse and reporting laws are strong enough, and abuse reporting practice in Vermont is strong enough, that we do not believe untimely deaths of people in the Home Based Waiver services would go unnoticed or unreported. There is no data available in Vermont to support that there is a significant problem with unreported or uninvestigated suspicious deaths in Vermont.

The Long Term Care Ombudsman Program believes some untimely deaths do occur that go unreported, and that other deaths that result from poor care are not identified or reported. The Ombudsman believes that all deaths should be investigated and that this would result in identification of systemic problems and would lead to improved care.

In order to investigate every death in the system (about 1500 – 1800 per year), the Office of the Chief Medical Examiner estimates that it would require 7-8 investigators and one clerical position. Assuming about 10% of those cases would require autopsy (@ ~\$1000 per with transport, x-rays, toxicology, etc.), the total would be about \$800,000-900,000 each year.

## **Options**

It appears there are a few options for addressing the concern.

Option #1. Investigate all deaths in the Choices for Care Long Term Care Program. This would include deaths in nursing homes and in the Home Based Waiver services (approximately 1500-1800 deaths), at an estimated cost of \$800,000-900,000 each year, primarily to increase the staffing of the Office of the Chief Medical Examiner.

Option #2. Create a Fatality Review Team, similar to one used in other states (Maine has such a team). Typically, such a team would meet at least quarterly and review deaths that the system became aware of that were untimely or suspicious. Since these would only be discovered deaths, the benefit of the team process would be to identify potential systemic problems and make recommendations for improvements in the system. Such a team also has the potential to raise awareness in the system about reporting untimely or suspicious deaths.

If the number of reported deaths was small, the team could elect to review a small number of deaths chosen at random to determine if any problems had gone unreported.

In some states, these teams are established in statute. We are not recommending statutory language at this time. We believe we could begin such a process informally without statutory language. If the process was valuable and the need for legislation was deemed necessary, it could be developed in the future.

Option #3. We can make some improvements to the system that are less costly.

- a. Improve information gathering on deaths in the Choices for Care Waiver. We could develop a system to identify all deaths by setting.
- b. Develop a written Memorandum of Understanding with the Medical Examiner's Office to ensure proper sharing of information is occurring.
- c. Develop a requirement for home based providers similar to the requirement for nursing homes that untimely deaths be reported to DLP.
- d. Study and make recommendations for improving the information provided by physicians on death certificates.

- e. DOH and DAIL will establish a Long Term Care Team to identify necessary requirements and resources to create and maintain an Elder Fatality Review Team.

DAIL and the Medical Examiner's Office prefer Option #3.